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## DIAGNOSTIC TRAINING OPPORTUNITIES

TINA E. BANGS\*

*Houston Speech and Hearing Center*

THERE is an increasing trend within medical centers to establish speech and hearing clinics which are designed to deal with persons who have communication disorders. It has become rapidly apparent that many of these patients have problems which are complicated by or directly attributable to various neurological, pediatric, geriatric, dental, otolaryngological, or physiological departures from normal. As a result, the speech pathologist and audiologist have become acutely aware of the need to learn more from medicine.

The majority of speech clinicians contemplate employment in public schools and often their theoretical as well as practical training is specifically geared to prepare them to operate within the classroom. The type of training they receive within a University setting may be limited in the types of cases they see. Very often, clinicians are exposed to medical correlates of problems in communication by text books alone, or with an occasional lecture from medical personnel. Within the medical milieu there is an increasing demand for professionally trained speech and hearing clinicians and diagnosticians, therefore our educational institutions are looking toward the medical centers to help expose students to a different kind of training situation. Perhaps speech and hearing programs operating within medical centers are in a unique position to assist in the training of speech pathologists and audiologists. The added benefits of such programs in conjunction with or subsequent to a nonmedical University setting appear to lie in three areas: (1) a large and varied population of individuals suffering from a wide variety of disabilities or illnesses, (2) numerous medical specialists usually anxious to coordinate their activities with those of other specialties in order to provide better service for patients, and (3) the latest diagnostic tools as well as technicians and professionals needed to utilize them.

In order to present the true flavor of a medical environment, interested in communication disorders, the writer went directly to persons currently engaged in allied professions. In view of the fact that each medical center in the United States has unique features, the Executive Director of the Texas Medical Center, Dr. Frederick C. Elliott, was invited to present the total picture and to point up, as he sees it,

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This article is adapted from a paper read at the National Convention of the American Speech and Hearing Association in Los Angeles, California, November 3, 1960.

the need for combined effort in diagnostic programs. Dr. Elliott has contributed the following to this panel:

A medical center should serve objectively to coordinate the efforts of all the medical research and education programs which are within its environment. If the efforts of coordination are successful, artificial barriers which prevent thorough and complete communication between institutions and individuals will be overcome or prevented. This is a continued effort in a medical center because the nature of specialized institutional programs often results in a lack of "horizontal" integration. Thus, gaps and overlaps result.

Even in university medical centers, the pattern of organization of departments in colleges and schools often prevents the development of interrelated programs. In a medical center such as the Texas Medical Center where institutions have specific objectives under independent boards of directors and administrators, the danger of separation is more acute. Yet, with a program such as ours, the growth and development of each institution is allowed to parallel the growth and development of the other institutions.

One of the first "institutes" to be established in the Texas Medical Center was the Speech and Hearing Center. The broad concept of the institute idea as understood and carried forward by the Director of our Speech and Hearing Center, has enlivened other directors of institute programs to give serious thought to, and active planning for, the integration of their programs—one with the other. For example, language difficulties of many scientists assembled in our Medical Center from various foreign countries has been studied and programs planned by the Speech and Hearing Center to help overcome communication difficulties. While this is a service program offered to our Medical Center by the Speech and Hearing Center, it has served a worthwhile purpose in other directions.

It is important that a Speech and Hearing Center play an active part in the development of communication programs in the Medical School, the Dental School, in the College of Nursing, the Rehabilitation Institute, the Cancer Institute, and others so that whatever relations are established, whether in orientation, teaching, or research, the aims and purposes of the Speech and Hearing Center can be clearly understood in order that the full services of the Speech and Hearing Center in the Medical Center will be utilized.

Likewise, it is equally important that persons in other fields such as psychology, social work, and other therapies be given the opportunity to attend medical programs so that they can medically evaluate their programs properly.

As Calvin Coolidge said, which is most applicable to total medical services, "We do not do as well as we know." This "not doing" is due too often to lack of communication between those serving in areas which are related one with the other. Some of this, no doubt, is due to the traditional pattern of permitting "degrees" to stand for knowledge. A medical degree does not provide a total knowledge

of a whole person in his total environment. For this reason, it is time that we establish the "team approach" to the prevention and treatment of the various deviations from the normal pattern of living so that living can be made more enjoyable for all. No discipline in a medical center is more vital to this accomplishment than is the Speech and Hearing program.

It was the writer's intention to indicate the ways in which a medical center speech and hearing clinic could contribute to the diagnostic training program of speech pathologists and audiologists. In as much as communication begins at birth it seemed logical to ask a pediatrician to illustrate ways in which pediatric medicine can contribute to our profession. Dr. Fred M. Taylor, pediatrician, has done this and has gone a step further. He has given numerous examples of current diagnostic research which should make all of us eager to be exposed and to stay exposed to the goings-on in a pediatric clinic. Dr. Taylor states:

I should think that it is important for speech pathologists and audiologists to acquaint themselves with pediatric clinics and procedures because pediatrics is concerned with everything that affects the health of children. It has the task of promoting improved health for children and adults; and of translating the basic work in biology, chemistry, and genetics into schemes of prevention and treatment.

In a diagnostic pediatric clinic, working with physicians and patients, speech therapists would perhaps get acquainted with the wide variety of conditions that account for primary and secondary communicative handicaps. As an example, over a dozen new blood type incompatibilities between fetus and mother—other than Rh and ABO factors—are known to exist, yet stimulate the Rh manifestations and complications. An increased number of respiratory and enteric-tract viruses, hitherto unknown and unidentified, doubtless account for instances of "subtle" encephalitis and focal brain damage which may otherwise be attributed either to forceps injury at birth or a head fall in late infancy. In addition, the use of antibiotic products may be associated with auditory toxicity, and the excessive use of vitamins and minerals with instances of neurotoxicity.

At the moment, in pediatrics, there is intense emphasis on the fundamental role of genetics and cell enzymes. The methods for counting the actual number of chromosomes in the cells of human beings have recently been facilitated. Infants with deafness, clefts of lip and palate and serious retardation are reported to possess only 45 chromosomes instead of 46. On the other hand, infants with mongolism may have 47. Another group of infants have either a reduction or absence of specific cell enzymes, resulting thereby in serious disability of liver, brain, and eye. Whether these recent developments will ever serve to explain specific or primary communicative disorders, though heretofore to be nongenetic, I, of course, don't know.

I should also think that it is important for speech pathologists and audiologists, as well as physicians and clinical investigators—whether in a medical center clinic or not—to stress the need for critical inquiry and for maintaining a critical mind toward evanescent programs. There is enormous need, as medical science and therapeutic efforts

grow more complicated and more and more enthusiastic, to avoid the superficiality of clinical automation, dehumanization, and therapeutic conformism.

Students in audiology learn to evaluate hearing problems through the media of textbooks, lectures, and clinical practicum in speech and hearing clinics. The same is true for such problems as cleft palate and voice disorders. If students had an additional advantage of spending time in an otolaryngology clinic, they would see the medical aspects of clinical cases and hear medical terminology which would open new doors for a better diagnosis of speech and hearing disorders. Dr. J. Charles Dickson, otolaryngologist, in his section of this paper has discussed the kind of diagnostic program that would enhance the learning situation of any student studying disorders of communication.

Everyone agrees that a student for B.S., M.A., or Ph.D. degrees in speech and hearing should thoroughly ground himself in the area of speech pathology and audiology. Also, I think most would agree that he should have information about the total person so that he would have a broader viewpoint of the patient's problem which is being treated. If the student knows only his own area of diagnosing speech cases and interpreting audiometric measures without understanding the anatomy, physiology, symptomatology, pathology and therapy indicated, he will do a much poorer job. In addition, he will constantly be coming in contact with various specialists in related areas. If he cannot talk their language, there is a barrier which prevents complete understanding, and the patient in the long run will receive poor treatment. This does not mean that a student should spend hours in the anatomical laboratory such as a medical student does or to spend an undue amount of time in the physiology lab doing laboratory experiments. But certainly he should be exposed.

The following points are ones that occur to me, where, in a complete medical center, the student could be introduced to the views of specialists in related fields so that he would, on completion of his course, be able to do a better job as a speech pathologist and audiologist.

1. Study human anatomy and physiology through lectures, demonstrations, and in the laboratory.
2. Receive lectures on symptomatology and pathology of otolaryngological problems with special effort being made to tie the pathology with the anatomy and physiology.
3. Spend time in the outpatient clinic where many otological problems are seen. It would be ideal if there were a special audiological and laryngological clinic.
4. Spend time in the operating room observing surgery on ears, such as vein grafts, tympanoplasty, and stapes mobilization.
5. Attend seminars where all specialists come together, such as the otolaryngologist, psychologist, audiologist, neurologist, pediatrician, speech pathologist, etc. At these seminars, difficult or problem cases would be presented and discussed from a diagnostic point of view.
6. Attend medical meetings where otolaryngological cases are presented.

7. Have conferences with the different specialists in order to ask questions on confusing points. This should not be a formal lecture type of arrangement, but more of a round table discussion.

In summary, I feel that the speech pathologist and audiologist should be thoroughly trained and grounded in his particular area, but in addition, he should have a broad viewpoint of the problem of the patient with some idea of the special techniques of all the medical and related specialists who might be involved in the case.

Two of the benefits that a student will derive from a diagnostic training program in a medical center speech and hearing clinic have been amplified; namely, diagnostic experience with a wide and varied population and contact with numerous cooperative medical specialists. The third benefit is concerned with diagnostic tools. It is informative to read about electroencephalography, but the student who can observe EEG in action gains added benefits. Dr. James W. Crawley, neurologist, has presented a discussion of some of the neurological diagnostic aids to which the speech pathologists and audiologist would be exposed in a medical center environment. In addition, he has discussed some of the current research that is closely tied in with speech and hearing. It is obvious that this kind of information should be a part of the diagnostic training program of all persons being trained in speech pathology and audiology. Dr. Crawley writes:

During the past 25 years, various techniques have been devised to help the neurologist and often the speech pathologist and audiologist establish a diagnosis of disease of the nervous system, or to help him localize a lesion if it has been suspected on clinical grounds. These diagnostic tests are often fairly difficult to perform, or require extensive experience in interpretation so that their use is almost limited to the large medical centers. Some of these tests depend upon introduction of contrast media into the nervous system, with X-rays being taken while the contrast medium is in place. Air is injected into the ventricular system (ventriculography) or through the spinal canal (pneumoencephalography) to identify space taking lesions of the brain or to demonstrate focal areas of brain atrophy, such as might occur along with communication disorders following a head injury or encephalitis. Arteriography is the injection of a radio-opaque dye into the blood vessels, an X-ray being taken when the dye is in the vessels of the brain. This is used to diagnose and localize space occupying lesions of the brain as well as vascular abnormalities. In the past several years, arteriography has been used to demonstrate occlusion or arteriosclerotic narrowing of the great vessels of the neck. This is of particular interest since disease of the vessels in the neck produces symptoms of brain disease, but the lesion in the neck is correctable by surgery—the vessel can be 'cleaned out' (endarterectomy) or replaced with a dacron vessel and blood supply to the brain restored.

Electroencephalography, the recording of the electrical activity of the brain, is used with increasing success in the study of various diseases which may be accompanied by communication disorders. Classically, EEG is used to diagnose and follow the therapy of the epilepsies. By alter-

ing cerebral oxygenation during the recording, either by having the patient inhale oxygen, thereby increasing cerebral oxygen supply; or nitrogen, thereby decreasing cerebral oxygenation, it is possible to differentiate brain tumors from reversible vascular lesions. Recently, an EEG abnormality was found to correlate with symptoms thought before to have other causes, namely episodic headache, abdominal pain, various autonomic disturbances, and behavioral abnormalities. These symptoms are now believed to be due to convulsive 'equivalent' attacks, and as such can be treated with the same drugs used in treatment of epilepsy. Using simultaneous EEG and electrocardiographic (EKG) recordings, recent studies have demonstrated that some attacks in children (breath-holding spells) are due to cerebral hypoxia secondary to cardiac arrest based upon hypersensitive vagal reflexes.

An up-to-date acquaintance with the kinds of information presented in the foregoing paper would be invaluable to all persons who work in the areas of diagnosis and rehabilitation. The tools for evaluation improve as medical science moves forward, and we, who deal in disorders of communication, must keep up with the times.

Each of the writers has indicated that there is a give and take among the various specialties in a medical center. For example, just as the student or professional staff in a speech and hearing clinic is learning from the various fields of medicine, so are members of the latter utilizing information from the area of communication. This, of course, leads to the development of interrelated programs which Dr. Elliott feels are so important to the success and progress of any medical center. Dr. William Fields, neurologist, has made an excellent contribution to this paper by emphasizing the need for "close cooperation and intercommunication." He states the following:

There are many ways in which the neurologist and the nonmedical professional persons concerned with disorders of human communication can work together in attaining a better understanding of the needs of patients and also in cooperative efforts in the area of basic research.

Sensory and motor disorders in both speech and hearing should be of concern to the clinical neurologist. In order to be complete, the training of every neurologist should include both didactic teaching and clinical experience related to these problems. In 1959 a lecture course in communication disorders was instituted as part of the residency training program in clinical neurology of Baylor University College of Medicine. The lecturers included persons well trained in audiology, speech pathology, otology and neurology. This course was enthusiastically received and will be repeated every other year. In addition to this, seminars have been conducted at the Speech and Hearing Center where persons from several allied medical disciplines could come out and participate in free discussion of complex problems. This has been of benefit to the therapist, teacher and clinician alike.

In pediatric neurology there are many occasions when the clinician finds it beneficial to have available to him the experience and special skills of the audiologist and speech pathologist. This relationship is best served when the persons involved can work in an atmosphere of close

cooperation and frequent intercommunication. For example, the close liaison between our children's neurological clinic and the speech and hearing center has enabled us to find many youngsters with retarded language or delayed reading capabilities who have potentially remedial situations. Previously many of the patients whom we believe could be helped, were diagnosed incorrectly as mentally retarded, emotionally disturbed or, frankly, psychotic.

In the adult age groups there are many persons with chronic neurological disabilities affecting communication who can benefit from programs jointly organized and jointly supervised by clinicians and nonmedical highly trained personnel. The clinician can assist in diagnosis and to some extent in offering a prognosis. The audiologist or speech pathologist can contribute in providing periodic reports of the patient's motivation and clinical progress. Much time and money can be saved for both the patient and the institution through such a relationship.

In both basic and clinical research the results of co-operative endeavor may be even more rewarding. One example in our own experience has been the development of new and improved diagnostic techniques for the anatomical localization of lesions producing certain specific audiological deficits. These techniques have enabled otologists, neurologists and neurosurgeons to feel more secure in the differential diagnosis of central nervous system and peripheral lesions. Those of us concerned with the development, teaching, research, and community service in

the neurological sciences in the Texas Medical Center look forward to even closer cooperation with our colleagues trained in the science of speech and hearing.

The contributions of a medical center speech and hearing clinic to professional diagnostic training programs have been summarized by five medical persons in allied fields. Their comments and suggestions can mean much to the growth of our profession and certainly warrant further discussion and elaboration.

#### Acknowledgments

The author is very grateful for the time given by the five medical persons who made such a fine contribution to this paper, and who know the importance of teaching students to recognize and make use of allied fields in the diagnosis of disorders in human communication.

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## TOWARD A PHILOSOPHY OF PROFESSIONAL BEHAVIOR

HEROLD LILLYWHITE\*

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**A**PPROPRIATE to a discussion of a philosophy of professional behavior is the wisdom of the Cheshire Cat in answer to Alice's question:

"Would you tell me, please, which way I go from here?" asked Alice.

"That depends a good deal on where you want to get to," said the Cat.

"I don't much care where—," said Alice.

"Then it doesn't matter which way you go," said the Cat.<sup>1</sup>

The Cheshire Cat's logic is, of course, logically unsailable. If we are destination conscious in the land of communicative disorders it may matter a good deal which way we go. To discover our destination, and to make satisfactory progress toward it, we must occasionally consider some of our major problems and basic needs.

A paramount need of the American Speech and Hearing Association, is to examine, from time to time, the professional behavior of its members, by which the profession is being judged; to describe as clearly as possible the scope and limitations of acceptable, mature, dynamic professional behavior; and to make this description readily available for the guidance of members of the Association. An equally important need is for individual members to examine critically and carefully their own professional behavior; to formulate a philosophy of professional standards and ethics of a high order; and to be guided by such a philosophy on all occasions.

As a profession we are making progress toward adequate standards of training and clinical competence; but in our overriding concern for these aspects, we have stumbled and groped at times with respect to professional and ethical growth. It is true that a statement of general principles of professional and ethical conduct is presented in our Code of Ethics; and, as a result of constant revision since the Code was first written, the section dealing with unethical practices—the "thou shalt nots"—has developed more and more into a useful guide to ethical conduct. The statement of principles and the description of unethical practices, however, are woefully inadequate and in-

effectual from the standpoint of the need they should serve. Perhaps this is because the profession is young and includes such an extremely wide variety of professional functions, activities, kinds of training, working situations, and degrees of competence that no document could reach all of such a varied group. Professional associations generally have little or no real police power, and our Association in particular is extremely ineffective as an investigative or punitive body. It is for these reasons that this writer attempts to comment on some of the aspects of our professional and ethical behavior; and to make some suggestions that perhaps extend beyond what is written in the Code of Ethics.

A Code of Ethics can never be a substitute for a strong, vigorous professional organization made up of competent, secure, and responsible members who enter practice with a clear understanding of what constitutes constructive, dynamic professional behavior. Our profession probably is being judged not so much by those who deliberately indulge in unethical and unprofessional practices, but by the many more who seemingly behave in an unprofessional and immature manner for lack of understanding of how to behave differently. Our profession will grow to a position of maturity and high esteem; not on the strength of its Code of Ethics, but on the basis of its individual member's clear understanding and mature practice of adequate professional behavior. The individual needs to know what to do and what not to do; but more important, he needs to know *how* positively to put into practice the professional principles that the Code states, as well as *how not* to engage in unethical practice.

An individual's behavior has meaning and consequence only when it is observed by others around him. One's professional behavior then, needs to be considered in terms of his relationships with other people and his influence upon them. To understand and develop a satisfactory pattern of professional behavior an individual needs frequently to re-examine his concepts; first, of himself as a professional person; second, his concept of other professional persons; third, his concept of his "cases," their parents and families; and fourth, his concept of his profession.

In thinking of one's concept of himself as a professional person, it seems necessary for him to ask a number of questions; such as, why did I become a speech pathologist? a clinician? an audiologist? a researcher? or a speech scientist? What are the principle satisfactions derived from my work? What are the real motivations that determine my functioning in my chosen work?

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This article is based on the writer's two years experience as a Member, and two years as Chairman, of the Committee on Ethical Practice, and from many years as a speech pathologist in a variety of positions and situations.

Answers to these questions will be as varied as the people who ask them; and many of the answers will be valid. Thinking about the questions, however, may aid one to discover whether or not his rationale as a professional person is sound, and whether or not he is maturing professionally. If the dominant continuing motivation is that of wanting to "help unfortunate people," one might wonder if this is sufficient for real professional satisfaction. Directors of training programs have come to look with considerable suspicion upon the candidate for training in speech pathology and audiology who presents this as his primary wish for entering the field. Frequently this person's real motivation turns out to be a need to manipulate people, perhaps to dominate, sometimes to meddle in other persons' lives, to gain control through means of his job that he cannot gain otherwise. It may be suspected that many of us had some such motivations when we entered the field. If these continue to be the dominant motivations, we are not growing professionally. Dr. Kenneth Scott Wood has said of the person in speech pathology or audiology: "It should require much more to keep him mentally alive than the emotional satisfaction which might come from helping the handicapped child. Without an overall sense of direction, relationship and purpose, grounded in the whole field of communication, he could very quickly find himself working in isolation with the speech mechanism, with phonemes, and with recording machines."<sup>2</sup> We might add, also, that he could very quickly, and sometimes does, find himself engaged principally in amateurish meddling with other people's lives.

Certainly, a continuing deep feeling for other people is important, and the desire to render service should be a major motivation; but considerable motivation also should come from an intense pride in the profession to which one belongs, the relationships one enjoys, the excitement of learning as much as one can about a very complex problem of communication as it relates to the infinitely more complex human being; stimulation of scientific endeavor, of investigation into any of the hundreds of problems yet unsolved in this field; and finally, the exhilaration of accepting and carrying out the tremendous responsibility that any professional worker takes upon himself when he engages in the diagnosis, treatment, and study of problems so intimately involved with the many aspects of the human being as are problems of communicative disorders. One's concept of himself, then, may be well beyond the limited concept that he is one who "helps unfortunate people."

The self-concept of a professional worker will relate closely to, and largely determine, his concept of other professional workers. It is helpful if I, as a professional worker, frequently ask myself: What is a "speech clinician," a "hearing clinician," an "audiologist," a "speech pathologist," a "speech scientist," a "research speech pathologist or audiologist"? What do I think

and know about the way these different professional persons work? Do I understand something of what motivates an individual to spend his life doing correlations on dry statistics having to do with remote problems in the field of speech or hearing? Am I impatient with him when he publishes the results of his research and expects me to be interested in them? What do I understand of the reasons why a person will spend his life in a laboratory, manipulating "gadgets," in the hope that he can get a little finer measurement of some individual's functioning with respect to communicative disorders? On the other hand do I, from my laboratory or university professorship look with lofty disdain "down" upon the school clinical speech correctionist and wonder how he can spend his days "working with artic. cases"? Perhaps my behavior toward these individuals would be more "professional" if my concepts of them were more accurate.

In the same connection, what are my concepts of professional workers outside the field of speech and hearing? How do I look upon the physician, the dentist, the psychologist, the social worker, and others? Am I secure enough that I can consider these other professional persons with the understanding which they deserve; or do I look upon them as threats to my professional status? Do I more frequently than not consider the physician with suspicion and resent his attempts to "diagnose speech cases," or to "tell me what to do"? Do I look upon others as intruders in my field if they are concerned about disorders of communication? Do I feel the need to embrace the whole area of communicative disorders for myself, and resent any others' interest in these disorders; or am I mature enough, and confident enough in my own profession and my own capabilities, that I can wholeheartedly accept the efforts of any other interested and capable person?

What are my concepts of my "cases"? Do I look upon the person with a communicative disorder as "a stutterer," "an artic," "an aphasic," etc.; or do I see him as another person in whom I have a genuine personal and professional interest, who is made up of all the complex characteristics that are common to other persons—but who, at this particular time, does not communicate as he should because at times he stutters, he does not articulate clearly, his verbal meanings are confused, etc.? Do I understand that with him, as with me, tomorrow or next week or next year he may not function at all in the same way as he does today? In other words, do I see him as a total person with a problem, rather than as a problem which just happened to attach to a person?

I need also to ask myself if I see in this "case" another person to manipulate, to give directions to, to control, to change; all with the best of intentions and the most refined professional technique. Or, do I present myself to him as a competent, mature specialist,

able to maintain sufficient clinical detachment to do an adequate job; and yet be warm and sympathetic and understanding without emotional involvement?

The final major question of concepts we need to ask is: What is my concept of my profession? I need to think of answers to such questions as: What is the profession of speech pathology and audiology? How does it stand among other professions? What are its stated purposes, its limitations, and its fields of endeavor? Do I represent my profession to others in a satisfactory manner? Do I have pride and loyalty for my profession, or do I just have a job doing things that happen to belong to this particular area? Do I see the relationship between the profession to which I belong and the professional associations within it? Can I confidently point to the professional organization that represents me as one of stature and maturity, to which I have contributed in whatever way I could? Am I really concerned with raising standards within my profession and promoting professional responsibility and ethical behavior; or do I feel that now I have arrived—let's leave things as they are? Do I see the dynamic nature of the service which I perform and the profession which I represent, and do I keep abreast of the change; or do I sit back with my bag of techniques and "work with cases," teach my courses, work in my laboratory in peaceful isolation from any organizational "interference"?

Perhaps wrestling with some of the above questions may be the basic step in the direction of establishing and maintaining a mature and growing professional pattern of behavior. In doing this it is well to attempt to consider in more detail some of our more frequent and significant professional relationships and activities, and to find ways to translate these in terms of satisfactory professional behavior.

The Code of Ethics states that it shall be unethical "to write or say anything which may discredit professional colleagues or members of allied professions other than that based on adequate and objective evaluation of their work." One may quite easily live within the letter of this restriction and still be guilty of unprofessional conduct in this respect. For example, there is intense and healthy rivalry among the many institutions in the country engaged in training people to enter various areas of speech pathology and audiology, yet many unhealthy attitudes develop out of this rivalry. It is not difficult to recognize graduates of certain institutions by the attitudes they express. Many of these attitudes are healthy, others are professionally damaging; such as the attitude that all other training institutions are inferior to one's own, or that, if a piece of research did not come out of "X" university it is not good research.

Closely related to this attitude is that generated by the situation in which dynamic and well-loved individuals in the field develop a following. At times their students, in effect, become evangelists. They may become critical of all other approaches—and

sometimes are somewhat fanatical in promoting one "method," one point of view, and one "school" of speech pathology or audiology.

These situations put individuals in a position of evaluating the professional competence of other individuals, not on the basis of their real performance, but on the basis of where they have been, whom they have trained with; in other words, on a status basis. There is nothing unethical about this kind of behavior from the standpoint of the Code of Ethics, but a highly unprofessional flavor subsists about it. The best interests of the profession become subordinated to the interests of institutions and individuals.

Another of the intangibles has to do with the handling of confidential information of speech handicapped individuals with whom we work. It is not difficult to remain within the letter of the Code of Ethics, to "not violate the patient's confidence by revealing any information obtained from or about him without his express permission," and to not reveal the identity of case histories used in teaching. But even while a person is remaining ethical in this sense, it is possible for him to use confidential information to try to build his own stature in the eyes of his students, his colleagues, or his friends, to impress people with the vast extent of his knowledge and activities; and at times to discredit all others who have previously been involved with a case. It is a tremendous temptation for the excited, interested clinician to "talk about his cases." The really professional person must develop a sense of the appropriateness of discussion about the people in his care. He must develop a feeling of responsibility and sensitivity for the inviolate confidentiality of any person's troubles and problems.

Still another of the intangibles in professional behavior has to do with one's knowledge of his competences and limitations, and his ability to function within these limitations. The Code of Ethics warns against guaranteeing results, continuing treatment after progress is no longer indicated, accepting for treatment those cases which cannot reasonably be expected to show improvement, etc.; but here again, something is needed which is far more important than adhering to these admonitions. It seems extremely difficult in our field for many to realize that, even though our training has given us acquaintance with all of the kinds of communicative disorders, it has not guaranteed that we are competent to diagnose or treat them all. Perhaps, because need for our services is great, it has become easy for us to accept the notion, which lay persons and sometimes our superiors often have, that because we have had courses in "aphasia," "stuttering," "cleft palate," "cerebral palsy," and other disorders, this makes us entirely competent to diagnose and treat communicative disorders arising from any of these difficulties. Perhaps we have assumed that we would be criticized if we refused to accept cases that we felt we should not take. In some situations this probably is a correct as-



sumption, but one must think of the unfavorable reflection upon our profession when we do accept a case we cannot understand and then fail; or in some instances, actually harm the individual.

The courage to say "I do not know" or "I am not equipped to handle a problem of this severity," is one that comes with experience and confidence. To some it never comes. Many experienced individuals have found that other professional persons will respect the speech pathologist, clinician or audiologist who is competent enough to know his own limitations, and to recognize problems that are beyond his ability to diagnose or treat.

The individual in private practice, in particular, is under strong pressure to accept all kinds of cases. His own income is involved as well as the esteem of others, including his clients. Likewise, the public school clinician is under the same pressure by the classroom teacher, the principal, and the parent, who all feel that if she calls herself a speech clinician—why can't she handle all speech problems? Mature professional behavior will enable a person to recognize his limitations and work within them.

A final intangible in professional behavior has to do with the role the professional person in speech pathology or audiology assumes and carries out among other professional persons. Perhaps it is here that we have least to guide us in experience and in our Code of Ethics; yet it is here we probably are judged most frequently. Our course and training materials have been borrowed from many fields and our students come from many disciplines. The problem with which we work frequently is only one of many problems in the same individual. Many times this places us in dependent or secondary roles. Many of the difficulties in our relationships, however, probably stem not so much from the nature of our activities as from the roles we voluntarily assume. At times we inappropriately accept the role of a technician working under direct orders and supervision of a physician or other professional person. We sometimes adopt medical jargon, and use it to sound learned rather than to assist in our better handling of a communicative disorder; and too frequently we make evaluations, judgments, and sometimes diagnoses, that are the province of the physician—not the speech or hearing specialist.

In other instances we have identified closely with the profession of psychology. This has been easy and quite natural because, for the most part, we have "taken" several psychology courses, and the problems we work with almost invariably are psychological problems also. We have not always resisted the temptation to make evaluations and judgments that would better be made by the psychologist.

Likewise, our role as to whether or not we are teachers has not been clear, so that our relationships

with those in education frequently have not been to our professional advantage. Sometimes we have found ourselves insisting vigorously that we are not teachers, but are clinicians. At other times we have insisted that we are not clinicians—we are teachers. We have resented having to take so many "education" courses and become certified as classroom teachers; yet we have accepted positions on public school faculties as "teachers" of the handicapped, and we have drawn our wages from this source.

Much of our confusion as to our legitimate roles certainly comes from our short existence as an independent profession, from the extremely varied nature of our backgrounds and our activities, and from our great insecurity with respect to our professional status individually and as a group. The intangible here is the need for mature independence of action, an adult professional stature that need not be subservient to any other profession, and yet will promote the closest kind of cooperative endeavor. The emerging strength of our professional organization gives great hope that we may have that guidance and that security to stand alone as a profession, and to behave without professional self-consciousness or apology. Perhaps the best way to achieve the independent, mature status that we desire is to build our professional organization as soundly as possible; as well as increasing our own personal professional stature through behavior of the highest type.

In summary then, some of the suggestions for consideration of the person in speech pathology and audiology, if he would work toward a pattern of professional behavior most consistent with his needs, are to re-examine frequently his concepts of himself as a professional person, of other professional persons, of the individuals with communicative disorders he serves, directly or indirectly, and of his profession. These concept-appraisals may be made not only in light of what the Code of Ethics spells out, but also in light of the intangibles that go beyond the Code to the innermost thoughts, feelings and attitudes of the individual himself.

Thus we return to the Wisdom of the Cheshire Cat: If we do not have a place to get to, it matters not which way we go. If we do have a goal, a purpose, a philosophy, it matters a great deal which way we go. Developing a mature, dynamic philosophy of professional behavior will enable us to avoid many hazards on the road we travel.

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# SPEECH PATHOLOGY (LOGOPEDICS) IN THE U.S.S.R.

RUTH MILLBURN CLARK\*

*University of Denver*

IN THE LATE summer of 1958, the author visited the U.S.S.R. with seventy other members of the Comparative Education Society. It is upon observations made at that time, and publications by members of the group (1, 3) that these remarks are based.

## GENERAL EDUCATION

In the U.S.S.R., Logopedics, the term used by the Russians for speech correction, is understood more completely if one is first aware of the pattern of general education.

While the people of the Soviet Union were largely illiterate forty years ago, they are now almost universally able to read, and many are highly educated. The pattern of education has gone through several changes, but none as a result of slow evolution. Modifications in educational patterns, if recommended by the Central Committee of the Communist Party and approved by the Party Congress, are relatively soon in general practice throughout the U.S.S.R. Henry Chauncey, in comparing American and Soviet education, said that results of research were put into action in the Soviet schools in four or five years, but that it took fifty years in the United States (2).

Because of the general employment of women, nurseries and kindergartens are maintained for the part time care of children from three months until the beginning of school age at seven years.

Extracurricular activities as we know them in American schools are provided in the Soviet Union by the Communist-line youth organizations: the "Octoberists," for the Kindergarten children, the "Pioneers" for the elementary and secondary school children, and the "Komsomols" for college students.

Incomprehensible as it may seem from the appearance of physical facilities, the Soviet Union spends a considerably higher ratio of its total income for education than is the case here (3).

## SPECIAL EDUCATION

Special education programs for handicapped children are found in the Soviet Union. The generally accepted term used is translated as "defectology." Pavlovian psychology (conditioned reflex) is the basic psychological approach. The Russians turn their backs on any segments of Freudian psychology and will not use standard intelligence tests. All pupils are con-

sidered of equal innate ability, therefore, success or failure is determined, according to Soviet theory, by motivation and hard work. Mental retardation is only recognized as associated with brain injury.

The special education field has received much less attention than has general education. Only in recent times has research been intensified on methods and means of helping the handicapped child. Research and pilot programs have led to improved techniques and expanded facilities, although much work is still necessary to bring the program up to date.

The aim of education of the handicapped in the U.S.S.R. is to help the children become, as far as possible, productive members of society. Schools for the physically handicapped, as well as schools and institutions for the mentally retarded and the mentally ill, have vocational courses and provide their graduates with jobs in industry and agriculture. Of the special schools, seventy percent are boarding schools and the majority of these are in the rural areas.

Handicapped children, except those having speech problems, are kept apart, not only from normal children but also from other categories of the handicapped. Blind children are kept with the blind, deaf children with the deaf, and so forth, in schools, summer camps, in recreation and in all social activities connected with school life. This isolation continues through life.

## PREPARATION OF DEFECTOLOGISTS

Research for the whole field of the education and care of the physically and mentally handicapped is carried on by the Institute of Defectology of the Academy of Pedagogical Sciences. The academy has branches in major cities. The following problems are studied and decisions made regarding them at the Institute.

1. The examination of children and the decision as to the program to be administered to them.
2. Development of special establishments. All of these come under the Minister of Education.
3. The development of content of teaching and the preparation of text books.
4. The development of methods for teaching children with particular problems.

The Institute has an acoustics, psychological, physiological, and speech laboratory. Teamwork of specialists is greatly stressed. Medical personnel, psychologists, research workers, speech pathologists and teachers all work closely together and pool their knowledge.

Students preparing to become defectologists (special education teachers) get fifty percent higher stipends

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The above talk was given by Dr. Clark at the National Convention of the American Speech and Hearing Association held in Los Angeles, California, November 1-5, 1960.

than do other college students, and when they become teachers they receive twenty-five percent higher salaries. Thus, there is no shortage of students or teachers in special education. The program of preparation covers five years and includes the equivalent of one year or more of laboratory work, observation and practice. In some instances, the fifth year is largely spent as an intern (3).

#### SPEECH CORRECTION OR LOGOPEDICS

The Department of Logopedics in the Institute of Defectology carries on research in the area of speech pathology. The Department decides on techniques and methods to be used throughout the Union, helps to train therapists, and exercises general supervision over speech correction.

The course of study for speech correctionists is five years, with students taking Anatomy; Logopedics, including clinical practice; Organic Defects; Aphasia; Articulation Problems; Stammering; and Techniques of Speech. Besides these specific speech courses, they have work in psychotherapy and auditory training.

Children with speech defects, unlike the other special education programs, attend regular schools and have special speech lessons. According to the Institute, there is a logopedist in every school. Special speech help is given individually, or in small groups, and each speech defective child learns phonetics.

Speech correction was observed in Dr. Levina's office, the Director of Logopedics in the Institute of Defectology in Moscow, and in Kiev, where Dr. Kraevsky, professor of logopedics, arranged a visit to a school where he maintained a demonstration research center. In addition, speech correctionists were observed in schools for deaf and hard of hearing children.

The incidence of speech defects in the Soviet Union seemed unusually low, and was reported in one instance at .5 percent. We were told that only seventy-four children out of sixteen thousand school children in Kiev had speech problems. This may indicate that speech correctionists concern themselves only with the most severe cases, for regular classroom teachers give much attention to speech; a course in phonetics is required in the preparation of all teachers. Since Russian is a phonetic language, it may be more easily spoken than English. In addition, it is possible that children with speech problems as a secondary handicap in special schools have been excluded from the count. However, it was reported that cleft palates occurred only once in four thousand to five thousand births, contrasted with one in seven hundred fifty births in America, which would suggest either lower incidence in Russia or incomplete reporting (3).

In the U.S.S.R., surgery on the lips and nose of cleft palate cases is performed during the first or second year of life, but surgery on the palate is

deferred until about the sixteenth year. This necessitates the use of a prosthesis throughout most of the school life of the child.

Speech defects are classified in much the same way in the Soviet Union as in America. Also, procedures in speech correction seemed much the same except that sound equipment and auditory aids were less in evidence.

Research was emphasized, but was apparently not as diversified and advanced as here in America, in spite of the fact that they were investigating many of the problems with which we are concerned.

Dr. Levina was engrossed in a research project relating agraphia and articulation. At first, it was thought that she was concerned with writing, but it later became evident that the relationship was between spelling and speech, the hypothesis being that failure to distinguish certain sounds clearly resulted in both spelling errors and faulty articulation. "It was interesting to note here that an aphasic child was declared of normal intelligence on the basis that he correctly assembled a puzzle. How a segment of an intelligence test can be scientific and valid while the whole test is not, is somewhat puzzling" (3, p. 301). The Institute was also investigating methods of distinguishing between speech problems, hearing handicaps, aphasia and mental retardation. This resolved itself into what we usually refer to as a differential diagnosis. Many of their ideas on speech and stuttering have been so well known abroad that they hardly warrant the special recognition they are receiving in the U.S.S.R.

Our attention was also called to small wire devices called "zonds." A zond is a wire apparatus that forces the tongue into a certain position for the production of a certain sound. Dr. Levina demonstrated the use of zonds with two boys. She felt zonds were an important aid in speech therapy and stated that a child could be cured of his articulation mistakes in two days with their help. One sound only is subjected to therapy at a time. Dr. Kraevsky, of the Department of Defectology of the Gorki Pedagogical Institute in Kiev, was somewhat indifferent to these devices, indicating quite dramatically that his index finger served equally well.

As in the United States, Dr. Kraevsky felt that preventative programs for stammering were the best. If normal disfluency is not allowed to develop into a full-blown stammer, the child has a better chance to develop normal speech. This can be done, according to Dr. Kraevsky, by putting him on silence for two or three weeks. If the stammer develops from shock, the use of sleep and silence is recommended. A didactical method of going from the easy to the complicated in seven different steps is used in the Ukraine to treat stammering. These steps are as follows:

1. Reading and speaking with the teacher. Then the teacher stops and the child continues alone.
2. Reflected speech: The teacher speaks and the child repeats.

3. The child tells a story from a well-known picture and answers questions of the teacher.
4. The child creates the story alone with the teacher asking questions.
5. The child creates a story from a strange picture and answers the teacher's questions.
6. The child creates a story from an unknown picture without questions.
7. Free speech: The child answers questions and carries on a conversation (1).

Phrasing exercises and psychotherapy are also used. In addition, it was felt that good results were achieved when the child was motivated to overcome his stammering and had assumed some responsibilities for the "cure."

The group was told that stammering falls into one of three categories:

1. Vocal-stammering—in which special exercises for the voice are given.
2. Breathing stammering—in which basic therapy is worked on and diaphragmatic breathing has to be taught.
3. Articulation stammering—in which tongue and lip gymnastics are taught.

In treating articulatory cases, the analytical-synthetic method was used. By this they meant the separating of words into syllables so that the component parts are understood, then putting them together again so that the child is aware of the whole word. The kinesthetic method, whereby the child is made aware of the feel of the different sounds, was also used.

Workers in logopedics are an intelligent, dedicated and enthusiastic group in the U.S.S.R. as in the United States. They are interested in research and in developing more and better techniques to help speech handicapped individuals. Care of the handicapped has been so long neglected in the Soviet Union, however, that work in this field has not progressed as far as it has in the United States.

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# Special Reports

## COUNTY SPEECH SERVICES: A CLINICAL PROGRAM IN THE PUBLIC SCHOOLS

GERALD G. FREEMAN\*

*County School District of Oakland County, Michigan*

**D**URING the past two years a new speech correction program has been developed in the County Schools Office of Oakland County, Michigan. This program is designed to provide supplementary clinical services to speech correctionists who practice in the 30 local school districts in the County. Its goal is to coordinate clinical and classroom practices in the schools.

From 1954 to 1960 the number of speech correction programs in Oakland County increased from 15 to 78. This rapid growth occurred in all areas of special education through the support of a county tax which provides funds in addition to those made available by the state. As a result, the need for county-sponsored itinerant programs has decreased, and the County Schools Office has become a consultative agency offering services to constituent districts.

In response to a request from speech correctionists, the County Schools Office employed a speech pathologist. The speech pathologist serves as a general resource person. His specific functions have been created to meet the expressed needs of the speech correctionist.

### DIAGNOSTIC SERVICES

One of the prime functions of the speech pathologist has been to serve as diagnostic consultant. On request of a speech correctionist in any district in the county, the speech pathologist conducts diagnostic examinations in the schools which the children regularly attend. The referring speech correctionist always is present at these examinations.

In some cases, a brief conference between the speech correctionist and speech pathologist is sufficient to formulate a workable diagnostic or treatment plan. In others, a "team" approach is necessary involving such school personnel as classroom teachers, principals, psychologists, visiting teachers (school social workers), and school nurses. It is the responsibility of the speech correctionist to organize the "team" when the need is indicated. The speech pathologist serves as a coordinator, providing additional information,

and assisting in the formulation of a uniform plan of treatment.

Periodically, day-long diagnostic clinics are held in classrooms for orthopedically handicapped children or mentally handicapped children.

### SPEECH CLINIC

The speech pathologist serves as Director of the County Speech Clinic. The Clinic is located at the County Schools Office. It offers intensive speech correction programs to children from the local districts. All speech correctionists working in the County may refer cases to the Clinic.

The staff of the Speech Clinic includes the speech pathologist, a clinic coordinator, two speech correctionists, and a caseworker. County personnel in the fields of psychology, remedial reading, mentally handicapped, and physically handicapped are available for consultation.

At the Clinic, school-age children attend group and individual classes for six weeks, two and a half hours a day, three days a week. Observation facilities are available so that speech correctionists, other school personnel, and parents may participate in the program. Regular staff meetings are held with the school personnel in order to coordinate the clinic and school programs. These meetings also serve as an in-service training experience for members of school staffs.

Parents are required to observe speech classes and discuss their children's problems with the caseworker at least once a week. In addition, they attend regular group meetings with a member of the speech staff.

Periodically, preventive-diagnostic programs are conducted for preschool children. During these programs speech-centered activities are demonstrated to parents. Weekly parent discussion sessions provide opportunities for reviewing these activities, discussing speech development with respect to other aspects of behavior, and gaining insight into speech problems.

Recently, experimental language-centered programs have been instituted at the Speech Clinic. These programs are held in coordination with teachers of the hard of hearing. They are designed to determine the special education needs of children with language problems and to effect appropriate room placement or develop a specific helping-teacher program for each child.

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This report is based on a paper presented at the 1959 Convention of the American Speech and Hearing Association.

The County Speech Clinic does not offer terminal programs. It was organized to treat: 1) Those cases who have severe problems and who are in need of intensive work to establish a firm foundation for further speech correction procedures. 2) Those cases who have been enrolled in the regular school program for a long period of time and who have not made substantial progress even though their speech problems are relatively mild. 3) Those cases which demand a period of observation and treatment as a means of arriving at a proper diagnosis. At the end of each program a report concerning progress, impressions, and recommendations is sent to the referring speech correctionist for use in further corrective procedures and educational planning.

#### LEADERSHIP AND TRAINING

Another function of the speech pathologist has been to assume a leadership role in the facilitation of additional County speech services. He investigates and evaluates available services and makes appropriate recommendations to the administration.

The speech pathologist participates in many educational programs. He is available to discuss speech correction at parent meetings as well as professional and community meetings. He develops and organizes a minimum of four annual in-service training programs for speech correctionists practicing in the County.

#### RESEARCH

In view of the fact that there are 180,000 school children in Oakland County, substantial opportunity exists for research in speech correction. It is hoped that research programs will become an increasingly important function of all speech correctionists in the County.

In summary, the speech correction services offered through the Oakland County Schools Office have been designed to meet the needs of a specific group of speech correctionists. The program is an attempt to bridge the gap between the schoolroom and the Clinic by providing supplementary speech services to local school districts through the County Schools Office. The program is flexible and everchanging. Hopefully, it contains ideas which are adaptable to other locales.

#### ACKNOWLEDGMENT

The author would like to acknowledge that the Oakland County Speech Clinic program parallels, in some ways, the Children's Division Program at the University of Michigan Speech Clinic. We are indebted to Dr. Harlan Bloomer and Miss Prudence Brown for providing educational experiences which served as the basis for the development of this program.

# Training the Speaking Voice,

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## ANNUAL ELECTION OF OFFICERS

The Annual Election of American Speech and Hearing Officers and Councillors was held in December, 1960. The final results of the election balloting and voting by the Association members have been tabulated. The following were elected:

James F. Curtis  
Elise S. Hahn  
Mildred C. Templin  
Joseph M. Wepman

President-Elect  
Vice-President-Elect  
Councillor-at-Large  
Councillor-at-Large



James F. Curtis  
President-Elect

JAMES F. CURTIS is Professor and Head of the Department of Speech Pathology and Audiology at the University of Iowa. He teaches courses and advanced seminars in Voice and Phonetics, Experimental Phonetics, and Laboratory Instrumentation.

Curtis is a member of the Armed Forces-National Research Council Committee on Hearing and Bio-Acoustics. He is also a member of the Iowa Committee on Hearing Conservation of the State Board of Health, and he is a member of the editorial board of the *Quarterly Journal of Speech*.

He received his Bachelor of Arts degree from Iowa State Teachers College and his Master of Arts and Doctor of Philosophy degrees from the University of Iowa. During the early part of World War II he was engaged in research in military voice communication problems at the Harvard University Psychoacoustic Laboratory and at the Waco Army Air Field Voice Communications Laboratory. His post-doctoral teaching career includes a brief period at Purdue University; he has been on the University of Iowa faculty since 1946. He is a member and Past President of the Iowa Speech and Hearing Association. He is a Fellow of the Acoustical Society of America, and he is a member of the American Association for the Advancement of Science and of the Institute of Radio Engineers, Professional Groups on Audio and Medical Electronics.

He has served the Association as a member of the Ethical Practices Committee, member-at-large of the

Executive Council, associate editor of the *Journal of Speech and Hearing Disorders*, member of the Publications Committee, and he is currently a member of the Education and Training Board of the American Boards of Examiners in Speech Pathology and Audiology.

His publications include co-authorship of *Speech Handicapped School Children*; Chapter 16, *The Rise of Experimental Phonetics*, in *A History of Speech Education in America*; and scientific and technical articles in *Journal of Speech and Hearing Disorders*, *Journal of Speech and Hearing Research*, *Quarterly Journal of Speech*, and *Journal of the Acoustical Society of America*.

His principal research interests lie in the area of acoustic and physiological investigation of voice and speech. He is consultant and technical adviser on a number of sponsored research projects in those areas.



Elise S. Hahn  
Vice-President-Elect

ELISE HAHN, vice-president elect, is Associate Professor of Speech at the University of California at Los Angeles. She obtained her A.B. from UCLA in 1932 and her M.A. from Wayne University, Detroit, in 1942. After the death of her husband, Dr. Eugene F. Hahn, in 1944, she accepted a Teaching Assistantship at Northwestern University, completing her Ph.D. there in 1947.

She went to Los Angeles as an instructor in Speech at UCLA in 1947. She established speech clinical facilities there in 1948. The Articulation and Voice Division of the UCLA Speech Clinic, under her supervision, now serves about fifty families a semester.

Mrs. Hahn is a co-author of *Basic Voice Training for Speech*, McGraw-Hill, and the editor of the revision of *Stuttering Theories and Therapies*, Stanford Press. She has written several articles for the *Journal of Speech and Hearing Disorders*, *The Speech Teacher*, *Western Speech*, and the *NEA Journal*.



She has served on a variety of committees in ASHA. This year, she is a member of the Program Committee, in charge of the subcommittee on Speech papers, and is an associate editor of the *Journal of Speech and Hearing Disorders*. She became a Fellow of the Association in 1952.

In the Speech Association of America, she was elected the first chairman of the Assembly in 1956, vice-president in 1957, and became national president in 1958.

During 1959-60, she served as vice-president of the California Speech and Hearing Association, and became their delegate to the House of State Delegates, in which she is now Parliamentarian.

Mrs. Hahn has one son and is now married to George Khoury.

Professionally, her main interests lie in the communicative methods and techniques for children with delayed speech and individuals with cleft palate, functional articulation problems and voice disorders.



Mildred C. Templin  
Councillor-at-Large

MILDRED C. TEMPLIN is Professor in the Institute of Child Development of the University of Minnesota. Her present teaching includes courses in the development of language and thought in children, and the psychology of handicapped children. She was the supervising clinician in charge of articulation at the Purdue Speech Clinic and worked for three years as a speech correction-

ist in the Wauwatoosa Public Schools.

She received her Bachelor's degree from the University of Wisconsin in 1936 in speech, and her Master's degree from the same institution in 1937 in speech pathology. Her Ph.D. degree was obtained from the University of Minnesota in 1947, with a major in child development. Since 1943, Templin has been concerned with child development, with emphasis on the development of speech, language, and thought. Over the years her research interests have been in the development of articulation, techniques of its measurement, and in the development of reasoning of children with normal and defective hearing. At present she is carrying on two major research studies supported by the U.S. Office of Education. One attempts to identify in kindergarten those children who will likely need speech sound articulation therapy in second grade. The other studies the verbal and nonverbal problem solving behavior of deaf and hearing children at six, nine and twelve years and again two years later. She is

currently a member of a committee consulting with the National Institute of Neurological Diseases and Blindness on the development of a speech, language and hearing examination to be given 36-month-old children as part of a longitudinal study of central and nervous system damage being carried on in fourteen centers. She is a Fellow of the American Association for the Advancement of Science, Society for Research in Child Development, and the American Psychological Association, as well as in the American Speech and Hearing Association.

She is currently serving the Association as an Associate Editor of the *Journal of Speech and Hearing Disorders*, and as the Association's representative on the Council of the American Association for the Advancement of Science.

She has published articles in such journals as the *Journal of Speech and Hearing Disorders*, *Child Development*, *The American Annals of the Deaf*, *School and Society*, *The Elementary School Journal*, and the *Journal of Pediatrics*. She has published two monographs: "Certain Language Skills in Children: Their Development and Interrelationships," and "The Development of Reasoning in Children with Normal and Defective Hearing."



Joseph M. Wepman  
Councillor-at-Large

JOSEPH M. WEPMAN is Associate Professor in Surgery and Psychology at the University of Chicago. He was born December 25, 1907. He obtained his A.B. degree from Western Michigan College of Education in 1931, his Ph.M. from the University of Wisconsin in 1934 and his Ph.D. from the University of Chicago in 1948. Wepman was Clinical Instructor in Otolaryngology at the University of Chicago from 1936 to 1955. He was also Lecturer in Psychology from 1948 to 1955. Wepman serves as Consultant in Psychology to the Veterans Administration. He was Research Psychologist, Director of the Aphasia Center and Chief Clinical Psychologist at Dewitt and Letterman General Hospitals of the Armed Forces from 1943 to 1946. He served as an associate editor of the *Journal of Speech and Hearing Disorders* from 1954 through 1957. He is presently serving as an associate editor of the *Journal of Speech and Hearing Research*. He is a member of the Board of Consultants of Little City, Chicago, Illinois.

Wepman is a member of the American Psychological Association. He is a Fellow of the Division of Clinical Psychology. He has been granted the Diplomate in Clinical Psychology by the American Board of Pro-

fessional Examiners in Psychology. He is on the Executive Council of the National Council of Psychological Aspects of Disability. He is a member of the Association for the Advancement of Science. Wepman is a Fellow of the American Speech and Hearing Association. He belongs to the United States Committee of the International Society for Welfare Cripples and the Chicago Speech Therapy and Audiology Society. Wepman is also a member of the Honorary Societies of Sigma Xi and Tau Kappa Alpha.

Wepman is widely known for his work and publications concerning aphasia. Primary among these are

his book, *Recovery from Aphasia* which was published in 1951 and the Halstead-Wepman Screening Test which he co-developed. Wepman has been an active clinician and researcher. Besides publishing widely in the areas of aphasia he has published articles relating to cerebral palsy, cleft palate, stuttering, esophageal speech and various aspects of the language process.

Currently he is conducting research in the psycholinguistics of aphasia, developing a primary language abilities test and is investigating the release of tension through medication in psychogenic speech disorders.



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# CALL FOR PROGRAM SUGGESTIONS AND PAPERS

## Thirty-Seventh Annual Convention of the AMERICAN SPEECH AND HEARING ASSOCIATION

November 5-6-7-8, Hotel Sherman  
Chicago, Illinois

THE ASHA Convention Program Committee announces a Call for Program Suggestions and Papers for the 1961 National Convention. Contributors are urged to submit abstracts and other program proposals immediately to insure that they may be given consideration during the planning stages for the Convention.

The Program Committee will continue the efforts of past Program Committees to upgrade the caliber of the Convention presentations. Program proposals will be carefully screened. The time available for the program will be less and the number of presentations to be scheduled will be fewer for the 1961 Convention than for the 1960 Convention. Contributors must supply sufficient information to the Program Committee to enable it to make judicious choices from among the proposals and to permit intelligent scheduling of the presentations selected. Since the program abstracts and summaries will be published prior to the Convention, they must be complete and in suitable publication form.

The organization of a program for a national convention is necessarily complex. Scrupulous adherence to both deadlines and forms for submitting program proposals is necessary if the Committee is to work effectively.

The Program Committee urges your active participation in planning the program. Any suggestions will be given careful consideration. If you wish to make a program proposal of any type, please read carefully the instructions given below.

### TYPES OF PROGRAMS AND SESSIONS

In the interest of serving the many and varied needs of the membership, a number of different types of meetings and sessions will be scheduled. For the purposes of clarification and uniformity of listings, the following descriptions and definitions are provided.

**Papers.** Papers may deal with experiments, investigations, theoretical formulations, clinical practices, philosophic considerations, and policy or procedures in the various settings of our professional practice. Papers from related disciplines will be considered.

**Symposium.** A symposium is a meeting or series of meetings involving the presentation of two or more formal papers on a given topic.

**Panel.** A panel presentation is an informal discussion of a given topic by a group of five or six experts. There are no speeches per se and the Chairman interjects just enough ideas to set the stage and to give direction to the discussion.

**Forum.** There are two types of forum: an open forum, which involves extended audience discussion of a topic that has been briefly outlined; and a panel-forum, in which a panel is used for defining the topic and participating in the discussion. In either type, a question period, with special inter-

rogators or selected written questions, may be used to guide discussion toward important implications.

**Workshop.** A workshop provides a structured learning situation in which the audience participates with the aid of resource persons.

### QUALIFICATIONS FOR PARTICIPATION

Both members and nonmembers may submit proposals and participate in the program.

In order to insure maximum participation by the membership, the Executive Council has ruled that each individual be limited to two appearances on the program. This ruling has been interpreted not to apply to those instances in which individuals are invited to participate or where they are chairmen of sections.

### REQUIREMENTS FOR PROPOSALS

All proposals for the program, including abstracts, must be typed in quadruplicate and may not exceed 300 words in length. *Deadline is April 1.* All communications concerning the program are to be addressed as follows:

D. C. Spriestersbach, Program Committee  
Chairman  
Department of Speech Pathology and  
Audiology  
University of Iowa, Iowa City, Iowa





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## OBLIGATIONS OF CONTRIBUTORS

Persons accepted to appear on the program thereby assume the responsibility to appear in person as scheduled and to adhere rigidly to the time limits assigned. Participants must agree that no substantial changes will be made in accepted proposals without advance approval of the Program Committee. Should unforeseen contingencies arise which preclude the appearance as planned, the contributor must supply a substitute by advance arrangement with the section chairman.

Contributors assume the further responsibility to cooperate with the abstracts editor by meeting such deadlines as he shall indicate in making any revisions of abstracts and summaries deemed necessary. The Program Committee wishes to insure uniform coverage and quality of the published abstracts and summaries.

## FORM FOR SUBMITTING PROPOSALS

*Identifying Data.* These data are required of all proposals:

1. Title of paper or program.
2. Name and advanced degree of each participant.
3. Name of the institution or laboratory with which each participant is affiliated.
4. Designation of work which was done to satisfy the requirements for an advanced degree and identification of the director of the study.
5. Identification of work which was done as part of a sponsored research project with name of the sponsoring agency and the project code number.
6. Time required for presentation.
7. Audio-visual equipment needed or special physical setting required. Participants are requested to consider carefully the advantages and disadvantages of duplicated handouts of graphic and tabular material over presentations by slide projectors. However, projectors will be furnished if requested.

## FORM FOR SPECIFIC TYPES OF PROPOSALS

*Contributed Papers.* Research papers are proposed by submitting an abstract which contains a concise statement of the problem, procedures, and results. Results and conclusions should be stressed. All data should have been collected and the analysis completed at the time that the abstract is submitted. Papers concerned with data which have not been completely analyzed by April 1 will be considered only by special arrangement with the Program Chairman.

Papers dealing with matters other than research are proposed by submitting a summary of the subject matter to be covered. The summary should include a statement of the hypotheses being examined and the conclusions and implications to be drawn from the material.

*Invited Papers.* Members are urged to suggest names of eminent scholars, researchers, or professional workers who could make a valuable contribution to the program. However, invitations to appear are extended only by the Program Committee.

*Symposia, Panels, Forums, and Workshops.* Members may suggest proposals for symposia, panels, forums, and workshops. All participants should be identified as indicated in *Identifying Data* section above. Proposals should include a statement of the purpose and significance of the presentation, and a description of the subject matter to be covered. The specific contribution of each participant should be indicated.

*Film Theater.* Suggestions concerning films appropriate for the Film Theater should be sent directly to the Chairman of the Film Theater Subcommittee, Robert J. Duffy, 2511 Hazelwood Way, Palo Alto, California.

*Scientific Exhibits.* Complimentary space for scientific exhibits will be available. Application for Space Forms may be obtained by writing the Executive Secretary, American Speech and Hearing Association, 1001 Connecticut Avenue, N.W., Washington 6, D. C.

## The Program Committee:

Stanley H. Ainsworth	George H. Kurtzrock
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*Local Arrangements.* Suggestions concerning matters pertaining to local arrangements should be sent directly to the Chairman of the Local Arrangements Committee, Earl R. Harford, School of Speech, Northwestern University, Evanston, Ill.

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Elements of Voice and Diction  
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Principles of Speech Correction: Stuttering  
Principles of Speech Correction: Public School Methods  
Diagnostic Procedures in Speech Correction  
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Speech Habilitation for Persons with Cleft Palates  
Seminar: Problems in Speech Pathology

For information write: Harold Westlake, Head, Department of Communicative Disorders, School of Speech, Northwestern University, Evanston, Illinois.

## SCIENTIFIC EXHIBIT AWARD WINNERS

ASHA 36th Annual Convention



Hans von Leden



Paul Moore



H. J. Rubin

An outstanding feature of the 1960 ASHA Convention in Los Angeles was the Scientific Exhibit Section. This innovation was so successful it may well become a permanent part of the future conventions. It will be repeated in the 1961 Convention in Chicago.

Awards were made for the two most outstanding scientific exhibits. The exhibits were judged on the basis of excellence of presentation, originality of work, teaching value and whether or not competent, well-informed demonstrators were present the major portions of the time. A committee of judges composed of speech scientists, audiologists and speech pathologists evaluated the exhibits and granted the awards. T. D. Hanley was the chairman of the judging committee.

The first award was presented to Hans von Leden and Paul Moore for their exhibit, The Mechanics of the Crico-Arytenoid Joint. The second award was presented to Henry J. Rubin for his exhibit, High Speed Cinematography of the Larynx.

### EXHIBIT DESCRIPTIONS

#### MECHANICS OF THE CRICO-ARYTENOID JOINT

Hans von Leden, and Paul Moore

The traditional concept of arytenoid motion requires modification as a result of recent anatomic, cinematographic mathematical studies. Current textbooks present different misconceptions of arytenoid motion such as a vertical axis of rotation or a linear lateral glide.

Mechanically, such movements would presume articular facets along the superior margin of the cricoid lamina, but anatomic dissections indicate a different arrangement. The articular surfaces are situated on the lateral aspects of the cricoid rim. The joint structure resembles an elongated, shallow, ball and socket joint; the longitudinal dimensions of the two facets are placed at right angles to each other.

This architectural arrangement permits two principal types of motion: (1) a rocking, or rotating movement around the axis of the joint, and (2) a linear glide parallel to this axis. The former represents a massive

movement which adducts and abducts the vocal processes of the arytenoid cartilages and the attached vocal cords. This internal form of rotation may be compared to the movement of a planet around its own axis. The distance of the vocal process from the axis of rotation provides the leverage for the substantial displacement of the vocal processes during the opening and closing of the glottis. Incidentally, the same rocking movement lowers the vocal processes in adduction and slightly shortens the vocal cords; conversely, abduction results in an elevation of the vocal processes, with a slight elongation of the vocal cords.

The linear glide is more limited in extent: in our specimens this excursion averaged two millimeters. Since this linear movement follows the longitudinal dimension of the cricoid facet its excursion extends between an anterior, inferior caudal position and a posterior superior cephalad position. In isolation this motion would tend to shorten or lengthen the vocal cords slightly during vocal adjustments, with minimum lateral displacement.

Hans von Leden is Associate Professor at Northwestern University Medical School in the Department of Otolaryngology and Medical Director of the Institute of Laryngology and Voice Disorders, Chicago.

Paul Moore is Professor of Voice Pathology at Northwestern University Medical School in the Department of Otolaryngology, and Director of the Research Laboratory of the Institute of Laryngology and Voice Disorders, and is a Fellow of ASHA.

Henry J. Rubin is Senior Attending, Los Angeles County General Hospital; Associate Attending, Cedars of Lebanon Hospital; Instructor, Department of Head and Neck Surgery, U.C.L.A. School of Medicine; and Fellow of the American College of Surgeons.



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The capsule surrounding the joint permits some freedom of motion except postero-medially where the arytenoid cartilage is anchored to the cricoid lamina by the strong posterior crico-arytenoid ligament. This arrangement permits a very limited swinging motion around this pivotal structure (at the insertion of the ligament). This *external* type of rotation is analogous to the rotation of a planet around the fixed star of its solar system.

*In vivo* all of the motions described actually form components of one synergistic movement. This combination explains the variety of complex adjustments characteristic of the crico-arytenoid joint during phonation, respiration, protection of the air way, and the lesser functions of the larynx.

Cinematographic studies of different subjects reveal the same characteristic motions. Because of the speed of laryngeal maneuvers ultra slow motion pictures are necessary to depict and analyze individual adjustments.

Mathematical calculations confirm the anatomic and physiologic evidence. Mathematical equations supported by different measurements from numerous anatomic specimens confirm the excellence of the architectural design.

The actions of the intrinsic laryngeal muscles are modified by the mechanics of the crico-arytenoid joint. For example, during adduction for phonation the vocal cords are not "stretched" (elongated); thus, the tension of the cords depends largely upon the contraction of the thyro-arytenoid muscle fibres (and the action of the crico-thyroid and extrinsic laryngeal muscles).

Additional details of this investigation are in the process of publication.

#### HIGH SPEED CINEMATOGRAPHY OF THE LARYNX

Henry J. Rubin

This exhibit demonstrated the equipment and technique for taking high-speed motion pictures of the human vocal cords, displayed panels of high-speed sequences in a variety of physiologic and pathologic conditions of the larynx, and depicted basic laryngeal structure and function by schematic drawings.

The photographic technique represents a complete departure from previous methods and has greatly increased the number of subjects whose larynges can be visualized and photographed. Rather than have the subject brought over a fixed laryngeal mirror, the laryngeal mirror is introduced into the mouth and the larynx visualized in the same manner as in an office examination. When the observer sees what he wishes to record, he activates the motor driven fastax camera by a foot switch and a four hundred foot roll of film is exposed in from three to four seconds. This is equivalent to 5000-8000 frames per second, a speed which

slows action of the vocal cords so greatly that each vibratory phase is clearly visible. Utilizing this technique a wide number of normal and abnormal situations have been photographically recorded, laryngeal dynamics in black and white and pathologic states in color.

The neurochronaxic theory of voice production (Husson's theory) was subjected to a careful analysis by this method and shown to be invalid. According to this hypothesis the vocal cords are capable of active lateral contractions during phonation by direct neural stimulation. This is in contradiction to prevailing opinion that the vocal cords are passive during phonation and thrown into vibration only by subglottic air pressure. The study was carried out on tracheotomized subjects with normal larynges and on untracheotomized subjects with unilateral recurrent nerve paralysis. Representative sequences were exhibited in poster form, and a sound motion picture was shown at one of the seminars.

The mechanism of the falsetto has been studied, and the major types of laryngeal action in the falsetto classified. The falsetto break, a phenomenon under discussion for centuries, was captured on film and its nature clarified. Still shots were displayed in the exhibit and a sound motion picture on the falsetto shown in the film theater.

A thirty-five minute motion picture of numerous laryngeal disorders was shown in the exhibit booth by means of a continuous run projector. Included in this film were high-speed sequences in hysterical dysphonia, cerebral palsy, myasthenia laryngis, ventricular band phonation, recurrent nerve palsy, cordal polyps, polypoid degeneration of the vocal cords, vocal nodules, the normal child, screamer's nodes in children, papillomata, leukoplakia, carcinoma, and esophageal voice. A number of these have not been previously demonstrated by high-speed photography. Those pathologic conditions manifesting significant color changes from the normal were photographed in color at 5000 frames per second.

Twelve laryngeal situations of interest to the speech pathologist were displayed in still form. Photographs of progressive stages of the vibratory cycle were mounted in series, thus giving the illusion of movement as the eye scanned them.

For purposes of general orientation a simplified schema of intrinsic laryngeal cartilages and muscles was depicted in color on a large poster with accompanying identification and short explanations of function.

High-speed photography has found pertinent application to laryngology both as an invaluable research tool and as a superb teaching adjunct. Motion pictures presented at the exhibit and reprints of published articles are available to members of ASHA on request of the exhibitor.

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# Your Committees in Action

## EDITORIAL STATEMENT

The work of ASHA is carried on, to a great extent, by the committees of the association. Although the purposes and the procedures of the committees are clear to the members of these relatively small groups, the membership of ASHA may not have an opportunity to know how many things our more than forty committees accomplish. *Your Committees in Action* is designed to inform the membership about committee policies, plans, and achievements.

This month, we present reports from two committees—one a standing committee charged with the preparation of the convention program, the other a newly-established special committee appointed to consider the specific communication problems of the aged. The chairman of each committee has provided information that should help the membership understand and appreciate the work being done for ASHA by these "action groups." C.G.W.

## PROGRAM COMMITTEE

The selection of the Program Committee was begun in early September, 1960. The final selection was completed at the convention in Los Angeles in November. It may be of interest to know how the selecting was done and how the Committee has been organized. Our interests and activities have been broken down into the following subdivisions:

**Speech and Hearing Science:** Chairman, John C. Webster, U. S. Navy Electronics Laboratory; Robert C. Bilger, Eye and Ear Hospital of Pittsburgh; James P. Egan, Indiana University; and Jozef J. Zwislowski, Syracuse University.

**Speech Pathology:** Chairman, Elise S. Hahn, University of California at Los Angeles; Walter W. Amster, Miami Rehabilitation Center for Crippled Children and Adults; David R. Dickson, Northwestern University; James C. Hardy, University of Iowa; Helen Knight, Evanston, Illinois, Township High School; James E. McLean, Kansas State Department of Public Instruction; Sheila G. Morrison, Ohio State University; Josephine Simonson, Mayo Clinic; Courtney Stromsta, Ohio State University; and Wayne L. Thurman, Eastern Illinois University.

**Audiology:** Chairman, Aubrey Epstein, University of Pittsburgh; D. Robert Frisina, Gallaudet College; Robert Goldstein, Jewish Hospital of St. Louis; Otto J. Menzel, University of Miami; June Miller, University of Kansas Medical Center; William F. Prather, University of Iowa; and Richard A. Winchester, Temple University.

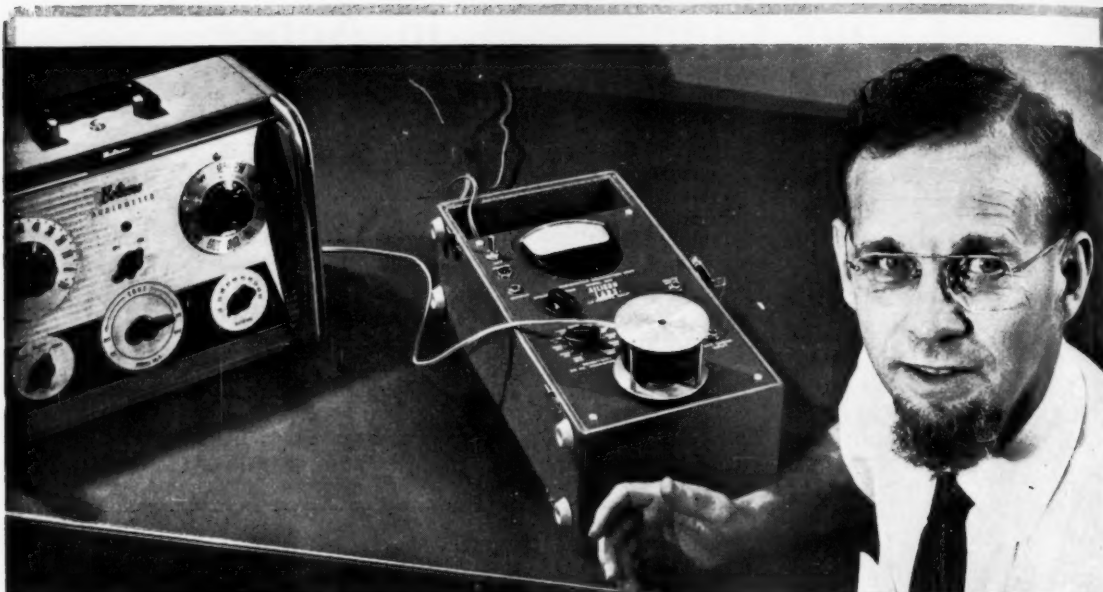
**Association Interests and Problems:** Chairman, Stanley H. Ainsworth, University of Georgia; H. Harlan Bloomer, University of Michigan; John L. Boland, Oklahoma Speech, Hearing, and Reading Center; Sue Earnest, San Diego State College; George H. Kurtzrock, Rehabilitation Institute of Metropolitan Detroit;

and Herold S. Lillywhite, University of Oregon Medical School.

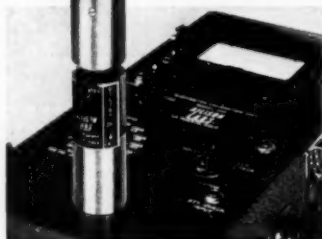
The public school activities are part of the responsibilities of the Speech Pathology subcommittee. Two of the subcommittee members, James E. McLean and Helen Knight, are active in this area and have been given the specific responsibility for developing the program plans that will be of particular interest to people working in the public schools. The group concerned with association interests and problems will develop programs on such topics as private practice, working with other professional groups, standards of practice, ethical practices, goals for our profession, international relationships, and others.

Developing a program involves more, of course, than reviewing and selecting material for the formal program. Abstracts must be edited and prepared for publication. This year Maryjane Rees of Sacramento State College has accepted this very difficult and time-consuming job. The Film Theater will be under the joint chairmanship of Robert J. Duffy of Stanford University and William E. Castle of Stanford University. And one of the most difficult jobs of all will be handled by Earl R. Harford, Northwestern University, as Chairman of Local Arrangement. We say this because we are expecting approximately 3000 people to attend the 1961 Convention. Gene R. Powers of the University of Iowa will serve as Administrative Assistant to the Chairman.

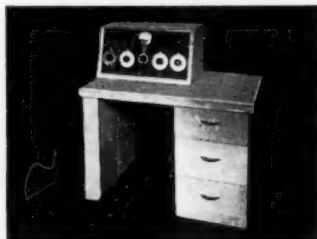
In selecting people to serve on the Program Committee we tried, in so far as possible, to select people who had not been previously or recently active in working on convention programs. We also tried to select people who represented the many different interests and areas of activity of the membership in the Association. Finally, and to a lesser degree, we gave



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some consideration to the geographical distribution of the members of the Committee.

The Call for Program Suggestions and Papers appears for the second time in this issue of *Asha*. In it we have stressed requests for program suggestions as well as abstracts of proposed papers. If the practices of past years are any index, we can expect to receive only a handful of suggestions. We sincerely hope that this year will be different. You, as individual members, can contribute immeasurably to the planning of the program by sending us your suggestions. It follows, of course, that the more suggestions and papers that are submitted, the more rejections there must inevitably be. We hope that you will understand if your suggestions or proposed papers cannot be used and will recognize that the Program Committee has had to make some judgments, which, it is hoped, will result in the best possible program.

Those of you whose papers are accepted or who accept responsibilities for chairing panels, symposia, or forums will have prepared abstracts or will be asked to prepare them. It is important to remember that abstracts serve not only to help the Program Committee select contributed papers and suggestions but also to help those attending the Convention to decide which sessions to attend and to provide a minimal summary of the Convention proceedings for those unable to attend. It is, therefore, paramount that we have complete and uniform coverage of the program and that abstracts reflect a high order of professional excellence. *In fact, the Program Committee feels so strongly about the importance of abstracts that it will not include items on the program unless abstracts suitable for publication are available.*

The Abstracts Editor has the tremendous responsibility to insure that abstracts are clear and complete and are published in a uniform format. You can help by following the instructions printed in the Call concerning their preparation. We know that we will have your cooperation in this difficult task.

This year the morning of the first day and the afternoon of the last day of the Convention will be devoted to short courses. These courses will be planned and supervised by a separate Short Course Committee under the Chairmanship of Ira J. Hirsh, Central Institute for the Deaf. The short courses will add a richness and depth to the Convention and will assist in providing for the individual needs and interests of the members.

The Program Committee wants the entire membership to feel that they can have an opportunity to participate in the planning of the 1961 program. The members of the Committee are working enthusiastically and pledge to do the best jobs of which they are capable. We hope that, with your help, the 1961 program will be the best ever.

D. C. Spiersbach, Chairman

## COMMITTEE ON COMMUNICATION PROBLEMS OF THE AGING

The Committee on Communication Problems of the Aging was appointed in May, 1960, by President Stanley Ainsworth. D. E. Morley was designated as chairman; Mary Huber, Gilbert Tollhurst, and Alfred Sokolnicki were selected as committee members.

The impetus for organizing an ASHA committee of this sort came from two sources: the White House Conference on Aging scheduled for January 9-12, 1961, in Washington, D. C., and an expressed interest in problems of communication among the aging on the part of individual members. ASHA is the logical organization to be concerned with communication problems which can arise during the later years.

During the months preceding the 1960 ASHA convention, committee business was conducted by mail. Material on many aspects of aging provided by the Executive Secretary and references on communication problems of the aging compiled by the committee chairman were forwarded to the committee members. The first task undertaken was to review this material with a view to determining what aspects could be incorporated into the work of the group.

On November 1, 1960, the committee met for the first time to plan the direction of its work. Halbert L. Dunn, Chief, National Office of Vital Statistics, U. S. Public Health Service, who is surveying programs for the aging in the nation, met with the group.

The discussion of this first session revolved around two main topics: the potential scope of the committee's work and activities which should receive first attention. It was the consensus of the group that at least five areas are of related interest to communication problems if the aging: research, teaching, liaison with agencies concerned with problems of the aging, the family of the aging, and motivation of the aging. The interrelationships among these five areas are apparent.

In the area of research, the following facets were recognized: establishing standards of ineffective communication in the aging, defining stereotypes of the role of the aging in our culture, investigating research needs in the area of communication problems of this group, formulating measures designed to prevent some of the communication problems, developing suitable compensatory measures aimed at ameliorating communication disorders, polling the membership of ASHA for suggestions concerning appropriate research topics in this area, and promoting discussion groups with older persons to seek first hand reactions and statements of needs when faced with communication disorders.

Teaching includes orientation of the membership of ASHA and organizations dealing with the aging to communication problems encountered among the aging and the training of professional speech clinicians



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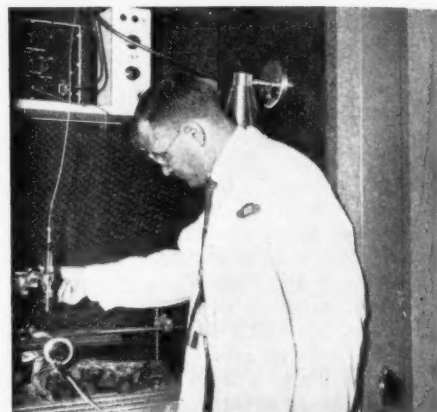
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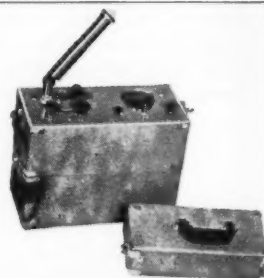


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who will work with such handicapped persons. Lectureships at colleges and universities, preparation of suggested college and university curricula, organization of symposia at future meetings of ASHA and at meetings of other professional organizations for the purpose of disseminating information concerning communication problems of the aging, and preparation of courses to be offered at hospitals and rehabilitation centers which serve the aging were among the topics listed under teaching.

Other agencies can be of real assistance in furthering the interest and activities of the Committee on Communication Problems of the Aging. National, state, and local groups should be advised concerning the interest of ASHA in communication problems of the aging and should be offered assistance in meeting such problems.

The family of the aging should receive pointed consideration. Such aids as descriptive material concerning communication problems of the aging, lists of referral agencies, and consultation services by qualified speech therapists should be of valuable assistance. An exploration of a family centered type of therapy should be made.

The last of the five areas related to communication problems of the aging—the motivation of the individual who has reached a level of unsatisfactory communication skill—has great significance. Motivation of the individual affects his acceptance or rejection of the problems and his acceptance or rejection of therapy. Hence, greater knowledge of motivational stimulants or deterrents in the aging will be of prime importance to the effective management of communication problems in this group.

The more the committee discussed the potential scope of the work of the Committee on Communi-

cation Problems of the Aging, the clearer it became that some limitations would have to be observed in the initial activities. Hence, the following were chosen for first attention:

1. The preparation of a semi-annotated bibliography on communication problems of the aging to be submitted to the *Journal of Speech and Hearing Disorders*. Dr. Atwood Hudson has agreed to prepare such a manuscript.

2. The preparation of a report on the preliminary work of the committee to be submitted to *Asha*.

3. The selection of a representative to function in a liaison capacity for the Committee at the White House Conference on Aging scheduled for January, 1961, in Washington. Parley Newman has been asked to contact persons attending the White House Conference who are affiliated with organizations or groups serving the aging to inform them of the interest of ASHA in communication problems of the aging, to urge them to make contact with ASHA for guidance in meeting such problems, and to encourage them to help in defining areas of research in such disorders.

4. A request to the program chairman of the 1961 convention of ASHA to include in the program a symposium on research in communication problems of the aging.

As these activities are put into motion, additional projects will be initiated by the committee.

Members of the Committee on White House Conference on Children and Youth of ASHA are: Mary W. Huber, Atwood Hudson, Parley W. Newman, and Alfred J. Sokolnicki.

D. E. Morley, Chairman

## IMPORTANT NOTICE

### *Clinical Certification and the "Grandfather Provision"*

Deadline for Receipt of Applications: June 15, 1961

APPLICATIONS for Clinical Certification under the grandfather provision will *not* be accepted after June 15, 1961.

An action of the Executive Council at the 1960 Meetings in Los Angeles placed a deadline on receipt of applications for certification under the grandfather provision. The deadline is June 15, 1961.

Certification under the grandfather provision is available to those who completed academic requirements prior to June 15, 1952. For details write to the American Speech and Hearing Association, Committee on Clinical Certification, 1001 Connecticut Avenue, N. W., Washington 6, D. C.



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# News and Announcements

## ORGANIZATIONAL

The 1961 Easter Seal appeal marks the fortieth year of service by the National Society for Crippled Children and Adults. The fund raising drive opens March 2 and continues through April 2. Art Linkletter is serving as national chairman of the volunteers. Workers at state and local levels will be implemented by national television, radio, and newspaper coverage. The projected campaign seeks funds to expand direct care and treatment for even more than the quarter million patients it currently serves.

Sigma Alpha Eta is the national professional fraternity for undergraduate students majoring in speech pathology and audiology. More than sixty-one chapters are active on campuses throughout the country. Kennon H. Shank, University of Oklahoma, is serving as national president for 1961. C. Cordelia Brong, University of Louisiana, is Executive Secretary. As one of its extra-curricular professional activities, the organization publishes a journal, *Keynotes*. Appropriate contributions may be submitted to the Editor, Alfred J. Sokolnicki, Marquette University, Milwaukee 3, Wisconsin.

The first issue of the *Journal of Speech and Hearing Association of Virginia*, has been published under the editorial direction of James M. Mullendore. The primary purpose of the *Journal* is to provide an outlet for members' contributions. Three such articles were contained in the first issue. Other departments include: personal news; professional SHAVings; and ASHA news. An editorial encouraging professional responsibility was written by the group's president, Libby Radus.

The Crippled Children's Program of the Children's Bureau, U.S. Department of Health, Education and Welfare, has been given a 1960 Albert Lasker Group Award by the American Public Health Association. A total of seven awards was given for breakthroughs in medical research and advances in public health programs. The Crippled Children's Program was cited for "pioneering a program of medical care which has vitally helped four and a quarter million handicapped children in the past 22 years." The award further stated "despite meager funds, the program has made wide use of the potential strength in each community and has added to the scientific direction and specialized knowledge necessary to develop better services. . . . Training of specialists in short supply has been supported." The award also pointed out that the demand for special services has increased each year, with the rate per 10,000 doubling in the past 22 years.

A research project to study patterns of rearing crippled and handicapped children has been launched by Milwaukee County's Easter Seal Handicapped Child Development Center. Approximately 1,000 parents of crippled and handicapped children will be interviewed. The study, supported by a three-year, \$100,000 grant from the National Institutes of Health, will be done in cooperation with the Jewish Vocational Services of Milwaukee.

A recent inquiry by the National Health Council indicates that more than 2,400 local and state affiliates of national organizations are participating in Health Careers Programs. The wide participation by these affiliates reflects the emphasis on "reaching the grass roots" among all the cooperating

national agencies. The inquiry also provided information on the participation of departments of health and education. In each of the 46 states represented, the department of health was reported as cooperating; in all but three, the state department of education was also indicated as participating. Local health departments and public school systems extend the state activity. ASHA was designated by eleven state and sixteen local affiliates as its national agency. In addition to the more than 100 national agencies reported, several of the Health Career groups included one or more of the large national insurance companies as "national agencies."

Samuel Rosen is leading an expedition of five otologists and audiologists on an eight-week study of a "noise free" African tribe. The Mobaan of the Sudan, which totals about 25,000 persons, is located in the bush 1,000 miles southeast of Khartoum, Sudan. Their culture has been described as belonging to the Stone Age. According to reports received by Rosen, the tribe has never been exposed to unusually loud noise of any kind—not even drums, firecrackers, or gunfire. The scientific group will use battery-operated equipment for the audiometric testing. Tribesmen of three age groups: 10-20; 30-40; and over 60, will have their hearing acuity measured. Interpreters will be furnished by the Sudan. Expenses for the Sudan mission are being defrayed in part by the African Research Foundation. Other members of the expedition will include: Mrs. Rosen; Aram Glogor, U.S.C.; Moe Bergman, Hunter College; Aly El Mofty, University of Cairo; Dietrich Plester, Dusseldorf, Germany; and Mrs. Plester.

The American Hearing Society and the St. Paul Hearing Society announce the Reine Humbird Myers Fellowships in Audiology and Agency Operation. These two \$7,000 grants provide for two years of combined graduate study at Northwestern University and the University of Chicago, with supervised field work in the Chicago Hearing Society. Each recipient must intend to accept an appropriate position in a hearing and speech setting affiliated with the American Hearing Society. Applications may be obtained from: Crayton Walker, Executive Director, American Hearing Society, 919 18th Street, NW, Washington 16, D.C.

## INSTITUTIONAL

The National Institute of Neurological Diseases and Blindness sponsored, in November 1960, a second medical mission to Russia. The scientists surveyed U.S.S.R. progress in the field of maternal and child care. A report of findings will be made available at a later date. NINDB's first mission to the U.S.S.R. surveyed Soviet research activities in the physiology and pharmacology of the nervous system. A copy of the report of that mission is available from the NINDB, Bethesda, Maryland.

In Ohio, a special state committee, appointed by Governor DiSalle, has recommended that Ohio's 88 counties take greater responsibility in the care of the mentally retarded. The report urged that new procedures for locating these individuals be developed, and that the counties and states share in their support and training. The committee also advised that the term, "mental retardate," be used instead of such terms as: mental deficiency, feeble-minded, idiot, moron, etc. Among the other recommendations was the expansion of legal interest in retardates below the age of six, and their legal protection

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beyond the age of 21. Local school districts should be required to provide classes for slow learners judged educable. A later report suggested that the state increase its payments to local school districts for classes for the retarded from \$300 to \$400 per pupil per year. This later report identified the Ohio program for retarded as one of the largest in the nation, with 2,843 children attending classes in 64 of the 88 counties in the state.

In Massachusetts, Harry C. Solomon, state commissioner of mental health, has outlined a plan for a network of state-wide community mental health centers. The plan calls for 25 new mental health centers to serve both children and adults; the expansion of 18 existing youth guidance centers; and 25 new preschool nursery centers for retarded children. Under the proposed program, the communities will provide, pay for, and maintain the physical center, and the state will supply professional staff. This new concept would represent the first large-scale change in 140 years of treatment.

Bradley University, Peoria, Illinois, provides a curriculum in speech pathology and audiology at both the Bachelor and Masters degree levels. To better publicize its facilities and the profession, the School of Speech Therapy has published a brochure, *My Future* (your career as a speech and hearing therapist). The booklet includes a description of the personal qualities needed; employment opportunities; curriculum requirements; and facilities at Bradley. Copies of the brochure are available from C. K. Mawhinney, Director.

"Help for the Speech Handicapped" was the title of a 13-week radio series conducted by Robert J. Ferullo, of Northeastern University, Boston, Massachusetts. The series was carried around greater Boston and New England by the Yankee network. His talks included such topics as: "Types of Speech Disorders"; "Speech Guides for Parents"; "The Child Learns to Talk," and "A Need for Speech Therapy and Therapists." Ferullo also appeared on a program, "Careers for Teenagers." On this program he was questioned by two high-school girls and the moderator about "Speech Therapy As A Career." The program was tape recorded and has been sent to 500 high school guidance departments in New England.

The Boston School for the Deaf and Boston University will inaugurate, in September 1961, a training program for teachers of the deaf. The program will lead to the Master of Education degree in Special Education. Further information is available from: Sister Mary Carl, Principal, Boston School for the Deaf, Randolph, Massachusetts.

#### PERSONALS

Sister Helen Daniel Malone, S.S.J., has been appointed President of Nazareth College, Rochester, New York, by the Board of Trustees. An alumna of Nazareth, she received her M.A. from Cornell University in 1943 and her Ph.D. from the University of Michigan in 1954. Since 1945 she has served as head of the Department of Speech, and was responsible for initiating a curriculum in speech correction at the College.

Dr. Wilder Penfield, founder and director of the Montreal Neurological Institute, presented a lecture at the National Institutes of Health, Bethesda, Maryland, on "Conscious Experience—What the Brain Records and Where."

Paul D. Holtzman is the author of an article, "Do You Listen to Your Child?" in the December issue of *Family Circle*.

#### NECROLOGY

Jack Chilton Cotton, professor of speech at the State University College of Education, New Paltz, New York, was killed in an automobile accident on October 3, 1960. Cotton received an A.B. degree from Maryville College in 1929 and an M.S. (1930) and Ph.D. (1936) from Ohio State University. He had been a member of the faculty at State University College of Education since 1950. Cotton was a Fellow of ASHA, and an active member of his profession for many years.

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# Forum

## DEFINITION

Several speakers at the recent ASHA convention used "normally hearing" as an adjective in describing their subjects. The same usage has appeared occasionally in recent journal literature. As a clarification, we suggest that for descriptions of subjects with normal hearing acuity a more appropriate modifier is the compound adjective "normal-hearing."

The basis of our suggestion is the fact that the word "normally" is an adverb (not an adjective) meaning "as a rule; regularly" (*American College Dictionary*, Random House). Normally hearing subjects, therefore, would be those who hear as a rule but who, at times (in death, for example), do not hear at all. We hope that our suggestion will be of some help to those who may have occasion to refer to individuals with normal hearing.

Joseph B. Chaiklin and Ira M. Ventry  
San Francisco Institute of Medical Sciences

## CERTIFICATION-COMPETENCY

It has been noted in the August, 1960, *Asha* (p. 268) that a report of a meeting of The American Association for Cleft Palate Rehabilitation states a criterion for membership in that organization which refers to the structure of clinical certification currently adopted by the American Speech and Hearing Association.

"A criterion for membership in the AACPR is that members shall be certified as clinically competent in their respective field of specialization. For people in speech pathology and audiology this means that advanced certi-

fication by the American Speech and Hearing Association is a minimum standard for membership."

The inference can be drawn from this statement of a criterion that the AACPR may have been informed that the clinical certification structure of the American Speech and Hearing Association should be interpreted to mean that only Members holding advanced certification are recognized as being clinically competent in the field of speech pathology and audiology. In regard to clinical competency our Association By-Laws state in Article XI, Section 2:

"The Association defines two levels of clinical competency, Basic and Advanced, in each of the separate areas, speech and hearing. . . . Certification by the Association shall be considered as evidence of clinical competency."

It can certainly be inferred from this section of our By-Laws that Members of the American Speech and Hearing Association holding clinical certification by the Association at either level are to be considered clinically competent. It would seem clear that the Basic Level is one of the levels of clinical competence recognized by the American Speech and Hearing Association and that, if information has been communicated to the AACPR that only the Advanced certificate is evidence of clinical competency, this information stands in contradiction to the By-Laws of our Association.

If our clinical certification structure is to be used as an effective means of representing our trained personnel to the public and to allied professional groups, the need for clarification is urgent. Perhaps this is one of our problems of professional growth which could be resolved through the establishment of a single level of certification.

James D. Bryden, Berks County Board of School Directors  
Reading, Pennsylvania

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